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ABSTRACT

The pamphlets in this packet describe the Montana Health Enhancement Curriculum, a comprehensive program that: combines the disciplines of health and physical education; offers a holistic approach to a quality life; and incorporates wellness principles into the public school curriculum. The program, developed by the Montana Office of Public Instruction in compliance with newly adopted state standards, seeks to educate children with respect to the importance of self-responsibility in achieving and maintaining a healthy lifestyle, encourages the establishment of health behaviors that can be maintained throughout life; and allows the principles of wellness to be integrated throughout the curriculum. The pamphlets include: a position paper that discusses the incorporation of comprehensive health programs into the public school curriculum, an introduction to the Health Enhancement Program; learner outcomes (K-12); resources; a conceptual model for a health enhancement curriculum; Montana's adolescent health status; a description of the comprehensive health education program that comprises a planned sequential K-12 curriculum addressing physical, mental, emotional, and social dimensions of health; and year 2000 objectives. (LL)

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ED 364 525

Health Enhancement

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Office of Educational Research and Improvement
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A Design for Montana's Future

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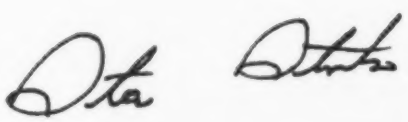
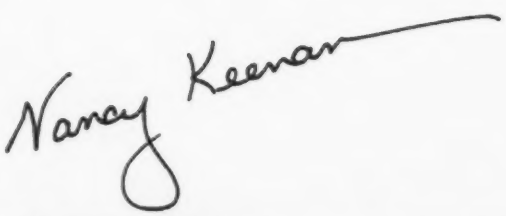
Learning to make healthy decisions for a healthy life is an important part of educating Montana's young people. Values learned at home and accurate information presented in our schools are two key components of this important education process.



Stan Stephens
Governor of Montana

Health Enhancement will give our students the information and skills necessary for them to make wise decisions concerning their own health related behavior as adults.



Nancy Keenan
State Superintendent of Public Instruction

The Health and Physical Education Committee of Project Excellence probably created the most far-sighted curricular guidelines of the entire Project Excellence project in developing the HEALTH ENHANCEMENT CURRICULUM. The concept was simple: both health and physical education are designed to assist students in becoming healthy, productive, and responsible adults. Since both meet the same goals, why not combine and enhance the efforts of each?

Although the concept is both logical and simple, it does represent an approach that is unique to Montana as well as the nation. Many of the learner outcomes that were established through the work of the committee are ones that are typically found in many curricula today and do not reflect a dramatic difference. What is different is the idea that physical education is actually the "lab" portion of a wellness program for students. Students not only learn principles of well-being, but put them into practice.

The HEALTH ENHANCEMENT CURRICULUM provides a common direction for both health and physical education programs and allows the principles of wellness to be integrated throughout the curriculum. This permits "curriculum infusion" and the possibility of health enhancement outcomes to be taught through science, home economics or other courses.

Health enhancement will not "hurt" or "destroy" a physical education program or a health program but, to the contrary, should enhance each. The direction provided by the HEALTH ENHANCEMENT CURRICULUM will give credibility to our programs and rationale for time and space within the school program.

Health enhancement is an integral component of a comprehensive health education program and should be K-12 in scope, age and developmentally appropriate, and infused into the entire school curricula. Health enhancement should be taught as a part of a larger system of adolescent health care which includes health services, community resources and the family. Curriculum development should reflect community values and the needs of adolescents.

A main ingredient of the health enhancement curriculum is the development of responsibility for one's own well-being. In an age where over 50 percent of the mortality and morbidity (death and disability) is due to personal behavior, education must give students the tools to make sensible and responsible health choices for themselves and their communities.

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Medical care costs have the potential to bankrupt society as we know it; health insurance premiums are increasing at an average of 20-40 percent each year. These increases in premiums result from three basic phenomena: medical care inflation; the failure of our society to confront ethical issues that center around the use of technologies (where our ability to prolong life is viewed as more important than death with dignity); and unwillingness of individuals to assume responsibility for personal health and the subsequent impact of this unwillingness on the responsible use of health care plans. It is the last two phenomena that are threatening our society, each contributing to rising medical care costs much more than inflation.

Medical care costs have the potential to bankrupt society as we know it.

Embedded within these phenomena are principles that appear to demand that everyone has access to all medical technology; that the extension of life for a few days, or weeks, is a more desirable approach to patient care than an environment where emotional support is provided to the patient and the family; where litigation is seen as a means to rapid economic growth; and the benefits pool is a bottomless pocket (this is true whether we view the benefits pool as being a federal source or the individual third party carrier that manages our benefits packages).

Evidence of the impending crisis in funding medical care delivery is everywhere. Medical care cost delivery now consumes almost 12 percent of the gross national product. Organizations are reducing the benefits to workers as part of negotiated wage settlements. Increases in the deductible portion of medical plans are commonplace. Employers are hiring more part-time workers in an attempt to avoid providing benefits. Worksite wellness programs are being established in an attempt to slow the upward spiral of medical care costs. Population demographics indicate a steady shift to an older population; there are fewer workers in the workplace to provide the benefits for those who have already retired. Since it is the elderly who require the most extensive medical care, it appears inevitable that we face a crisis.

There is a change in the nature of the disease states that physicians and hospitals are treating. There has been a shift from treatment of infectious diseases to the treatment of chronic diseases (i.e., heart disease, cancers, and stroke); we must now include with these chronic diseases the treatment of mental health problems - including drug and alcohol abuse - many of which are reflections of our lifestyle (social) behaviors.

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Medical technology permits us to extend life in ways that we never dreamed only one or two decades ago. When these new technologies are coupled with social behavior that encourages litigation, and we place the decision for the use of the technology with the physician, we put the physician in an untenable position. To fail to use a technology invites suit for malpractice; to use the technology may bankrupt the patient or the family. There is little doubt concerning the outcome of this dilemma.

We have the opportunity to institute comprehensive programs that emphasize a holistic approach to a quality life.

When to use a medical technology is an ethical issue. However, it clearly has an economic impact. During the last ten years, we have seen the appearance and spread of a disease for which we have no cure. At this point in time, the spread of this disease follows a typical exponential growth pattern. The potential economic impact of this disease is terrifying; the emotional and social impact we are already beginning to experience. Suggesting that we confront the ethical use of technologies in no way implies that we should **not** extend every measure possible to find a cure for diseases or that we should not use every technology at hand to retard the progress of a disease in an individual or in our society. However, there is some point where death becomes inevitable, where dignity and privacy are gone, and interventions merely prolong the dying process. It does not seem right to ask a family to decide on the use of a technology while they are experiencing the loss of a loved one. We need to initiate a dialogue regarding the future, a dialogue that is sensitive to human needs as well as economic reality.

The second issue identified was the unwillingness of individuals to assume responsibilities for personal health and responsible use of health care plans. An examination of the rising costs of providing medical care indicates that the increases result, in part, from inflation in physician and hospital charges for services, but that these increases, generally, reflect national inflation rates. Major increases in costs reflect the delivery of more services per episode, per illness; and the fact that individuals are visiting their physicians more frequently. A partial answer to the impending crisis in providing medical care may lie in ethics education; attempting to educate young Americans (who eventually become older Americans) regarding the ethical use of benefits traditionally afforded to the American public by developing and encouraging a sense of social responsibility.

Physical educators and health educators have more to offer our society in this regard than most other professionals. Our concern is for quality of life. Quality of life for all people, not just the sick, or the elite, but all people. We have the opportunity to institute comprehensive programs that emphasize a holistic approach to a quality life.

The public is not unaware of the wellness movement. Parents will demand a more complete education for their children, but incorporating wellness principles into the public school arena will introduce its own series of problems.

The most dramatic implication for the future is that there will be a need for professionals who are knowledgeable regarding holistic health. Neither the traditional health educator nor the traditional physical educator can meet the needs of the future. (To refuse to change the manner in which we prepare professionals will be to condemn one or the other profession.) We can no longer afford the luxury of arguing why our specific specialization is more relevant than some other. We must cooperate to redefine our goals and establish our contribution to the future.

The public is not unaware of the wellness movement. Parents will demand a more complete education for their children, but incorporating wellness principles into the public school arena will introduce its own series of problems. To adequately address the issues that face our society will require a change in the manner in which we approach health and physical education. The economic reality of the 1990s and beyond will require that we reconsider the manner in which we invest our time with children in the public schools. In many communities there is no differentiation between the athletic program and the physical education program; coaches are often seen as fulfilling more important roles than physical educators or health educators. We wear the "win at all cost" ethic like an albatross. Health education is still viewed as the bastard child of physical education in many communities, and health education has suffered as a consequence.

We need a new approach to the old physical education and health curriculum. An approach that centers upon health enhancement through self-responsibility; an approach that integrates lifestyle management throughout the curriculum and focuses on the total self, not just activity and sport. The Health Enhancement Curriculum is an attempt to meet these challenges and prepare socially responsible citizens for the future.

A comprehensive health enhancement curriculum will develop skills for daily living and prepare individuals for their roles in our culture. Educators and citizens must guarantee that efforts are made to emphasize health as a value in life and reaffirm that social responsibility is an essential element in our culture. We must develop educational programs that nurture critical thinking skills and ethical decisions regarding personal and community health behaviors. A quality health enhancement curriculum will motivate children to voluntarily take an active role in protecting, maintaining, and improving their health, while, at the same time, sensitizing them to critical ethical and moral issues that confront our society.

The future lies in a united front. As professionals, we must focus on our common goals, rather than seeking identity in our uniqueness. We must develop the notion of the health enhancement curriculum in our schools and for the general public beyond the school years, we must seek to educate our children regarding the importance of self responsibility and health promotion behaviors throughout their lives.

The future lies in a united front. As professionals, we must focus on our common goals, rather than seeking identity in our uniqueness.

The HEALTH ENHANCEMENT CURRICULUM seeks to educate children regarding the importance of self-responsibility in achieving and maintaining a healthy lifestyle. Its purpose is to help young people take an active role in protecting, maintaining and improving their health while, at the same time, sensitizing them to critical ethical and moral issues that confront our society. It integrates lifestyle management throughout the curriculum and focuses on the total self. It addresses intellectual, social, emotional and physical dimensions of self in addition to games and sport. It emphasizes health as a value in life and enhances critical thinking, decision making and problem-solving skills.

Taken from Montana School Accreditation Standards and Resources Manual
Sub Chapter 13
Health Enhancement Program

It helps them actively protect, maintain, and improve their health and sensitizes them to society's critical health issues. The Health Enhancement Program is a comprehensive program that combines the disciplines of health and physical education. The present separation of these two critical elements is not in the best interests of our children. Healthy, well-nourished children learn better. A healthy state transcends the physical and includes mental, social, physical, and intellectual dimensions of self. Quality of life, health care, and the containment of health care costs will be major issues for all Montanans in the next century. By sensitizing our children to health care issues and establishing and encouraging health behaviors that can be maintained throughout life, we can positively influence Montana's future.

RULE 10.55.1301 HEALTH ENHANCEMENT PROGRAM (In accordance with ARM 10.55.603 and ARM 10.55.1001)(1) In general, a basic health enhancement program shall: (a) Integrate lifestyle management throughout the curriculum. (b) Focus on the total self and the development of responsibility, values, attitudes, and behaviors. (c) Give students decision-making tools for personal health. (d) Address intellectual, social, emotional, and physical dimensions of healthy lifestyles. (Eff. *7/11/89)*

RULE 10.55.1302 HEALTH ENHANCEMENT PARTICIPATION (In accordance with ARM 10.55.603 and ARM 10.55.1001)(1) Each student shall participate in a health enhancement program which is based on age, ability, and aptitude.
(Eff. *7/11/89)*

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HEALTH ENHANCEMENT LEARNER GOALS: PRIMARY

(In accordance with ARM 10.55.603 and ARM 10.55.1001)

(1) By the end of the primary level, the student shall have had the opportunity to:

(a) Demonstrate a variety of perceptual, motor, and rhythm skills, including but not limited to throwing, catching, kicking, striking, balancing, creative movement and folk dance, and skills related to lead-up games.

(b) Demonstrate an appropriate level of physical fitness in cardiorespiratory function, body composition, and musculoskeletal performance.

(c) Develop positive interpersonal relationships and self-concepts.

(2) By the end of the primary level, the student shall have had the opportunity to identify:

(a) Components of wellness and describe how decision making affects personal health practices.

(b) Roles, responsibilities, contributions, and life cycles in a family structure.

(c) The difference between use and abuse of drugs and their effects on an individual's total development.

(d) Safety hazards, causes of accidents, and preventive measures for disease control.

(e) Human body parts and systems, emphasizing individual uniqueness.

(f) Ways in which advertising influences personal health choices.

(g) Food combinations that provide a healthy and balanced diet.

(h) Potential sources of pollution and pollution's harmful effects.

(i) Resources which help promote and maintain community health. (Eff. *7/11/89)*

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HEALTH ENHANCEMENT LEARNER GOALS: INTERMEDIATE

(In accordance with ARM 10.55.603 and ARM 10.55.1001)

(1) By the end of the intermediate level, the student shall have had the opportunity to demonstrate:

(a) A variety of physical skills that influence individual physical development, including but not limited to skills practice and lead-up games, rhythms and dance, and individual, dual, or team sports.

(b) An appropriate level of physical fitness in cardiorespiratory function, body composition, and musculoskeletal function.

(c) Positive interpersonal relationships and self-concept.

(d) An understanding of the importance of regular and sustained physical activity throughout life.

(e) An ability to identify roles, responsibilities, contributions, and life cycles in a family structure.

(2) By the end of the intermediate level, the student shall have had the opportunity to understand:

(a) Substance use and abuse and their effects on the individual and society.

(b) Health problems, including diseases and their etiology, the identification of symptoms of a variety of health problems, and prevention of health problems and injuries.

(c) The functions and maintenance of body systems, including knowledge of the reproductive system.

(d) The need for and use of consumer health services and products.

(e) Basic nutrition and its application.

(f) Cultural, environmental, social, and ethical issues which affect healthy lifestyles.

(g) Interrelationships between physical health and mental well-being. (Eff. *7/11/89)*

HEALTH ENHANCEMENT LEARNER GOALS: UPON GRADUATION

(In accordance with ARM 10.55.603 and ARM 10.55.1001)

(1) Upon graduation, the student shall have had the opportunity to:

(a) Demonstrate a variety of physical skills used in physical activity, including but not limited to dance, individual, dual, or team sports, and lifetime leisure and recreational activities.

(b) Demonstrate an appropriate level of physical fitness in cardiorespiratory function, body composition, and musculoskeletal function.

(c) Understand the importance of a positive self-concept and interpersonal relationships for total health.

(d) Understand the role of lifelong physical activity and the principles of safe and effective exercise, be able to plan a personal fitness program.

(e) Understand roles, responsibilities, contributions, and life cycles in family structures.

(f) Understand the risks of using drugs, alcohol, and tobacco.

(g) Understand attitudes and behaviors for preventing and controlling disease and accidents.

(h) Understand human reproduction and the emotional and ethical components of human sexuality.

(i) Be able to evaluate and select health services, practices, and products.

(j) Understand the relationship of sound nutrition to total health.

(k) Understand the consequences of personal and community decisions that affect the economy and the cost, availability, and quality of health care.

(l) Understand the relationship of sound mental health practices to total health.

(m) Identify careers in health and physical activity and their roles and responsibilities. (Eff. *7/11/89)*

HEALTH ENHANCEMENT PROGRAM DEVELOPMENT

(In accordance with ARM 10.55.603 and ARM 10.55.1001)

(1) The health enhancement curriculum shall be developed and evaluated according to the standards for all program areas.

(2) Areas of the health enhancement curriculum integrated into other subject areas are ancillary to the main health enhancement program, which shall be provided by a health enhancement specialist (K-12) or by a classroom teacher in the elementary grades.

(3) Interscholastic sports and intramural programs shall not be used as a substitute for a health enhancement course.

(4) Recess shall not be used to fulfill health enhancement requirements.

(5) When required as part of the basic education program, all students shall have daily health enhancement activity.

(6) The school district shall encourage its teaching staff to exemplify healthy lifestyles.

(7) A telephone or communication device and basic first aid materials shall be located in close proximity to the instructional physical activity area. (Eff. *7/11/89)*

There are multitudinous resources available to those who teach health education. The following outline is not all-inclusive but does identify selected sources of health information and materials.

The National Health Information Clearinghouse (NHIC), part of the Office of Disease Prevention and Health Promotion, United States Public Health Service, is a central source of information and referrals for health questions. The NHIC has identified many groups and organizations that provide health information to the public. When a person contacts the NHIC with a question (1-800-336-4797), the Information Services staff determines which of these resources can best provide an answer. An NHIC staff member contacts the resource, which responds directly to the questioner. The NHIC staff can only provide health information; they cannot give medical advice, diagnose, or recommend treatment. In August of 1984, the NHIC published the following adapted list of "Selected Federal Health Information Clearinghouses and Information Centers." The federal government operates a number of clearinghouses and information centers, most of which focus on a single topic, such as drug abuse or high blood pressure. Their services vary but may include publications, referrals, or answers to consumer inquiries. The information resources listed below are arranged in alphabetical order by key word, which is the term or terms appearing in **bold type.**

National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD 20850; (301) 762-5111. Provides referral and information on AIDS-related organizations and their services, as well as information on educational materials. Also supplies publications from the U.S. Public Health Service.

National Clearinghouse for ALCOHOL AND DRUG Information, P.O. Box 2345, Rockville, MD 20852; (301) 468-2600. Gathers and disseminates current information on alcohol and drug-related subjects. Responds to requests from the public, as well as from health professionals. Prepares bibliographies on topics relating to alcohol. Distributes a variety of publications on alcohol and drug abuse.

National ARTHRITIS and Musculoskeletal and Skin Diseases Information Clearinghouse, P.O. Box AMS, Bethesda, MD 20892; (301)468-3235. Distributes information to health professionals and consumers. Identifies materials concerned with arthritis and musculoskeletal and skin diseases and serves as an information exchange for individuals and organizations involved in public, professional, and patient education. Refers personal requests from patients to the Arthritis Foundation.

National Library Service for the BLIND AND PHYSICALLY HANDICAPPED, Library of Congress, Washington, DC 20542; (202)287-5100. Works through local and regional libraries to provide free library service to persons unable to read or use standard printed materials because of visual or physical impairment. Provides information on blindness and physical handicaps on request. A list of participating libraries is available.

CANCER Information Service, National Cancer Institute, Blair Building, Room 414, 9000 Rockville Pike, Bethesda, MD 20892; toll-free lines (800) 4-CANCER, Hawaii (800)524-1234 (Neighbor islands call collect); and in Maryland (301)427-8656 (program information only). Provides cancer information to patients and their families and the general public. Distributes National Cancer Institute publications.

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Clearinghouse on CHILD ABUSE AND NEGLECT Information, P.O. Box 1182, Washington, DC 20013; (703)821-2086. Collects, processes, and disseminates information on child abuse and neglect. Responds to requests from the general public and professionals.

National CHOLESTEROL Education Program Information Center, 4733 Bethesda Avenue, Room 530, Bethesda, MD 20814; (301)951-3260. Provides information on cholesterol to health professionals and the general public.

CONSUMER Information Center, Pueblo, CO 81009. Distributes consumer publications on topics such as education, food and nutrition, health, exercise, money management, Federal benefits, and weight control. The Consumer Information Catalog is available free from the center at the above address.

National DIABETES Information Clearinghouse, Box NDIC, Bethesda, MD 20892; (301)468-2162. Collects and disseminates information to consumers and health professionals on diabetes and its complications, planning and implementing educational programs, and evaluating educational materials. Maintains an automated file of educational materials on the Combined Health Information Database.

National DIGESTIVE DISEASES Information Clearinghouse, P.O. Box NDDIC, Bethesda, MD 20892; (301)468-6344. Provides information on digestive diseases to health professionals, patients, and their families.

ENVIRONMENTAL PROTECTION AGENCY, Public Information Center, 401 M Street, S.W., Washington, DC 20466; (202)382-2080. Provides public information materials on such topics as hazardous wastes, air and water pollution, pesticides, and drinking water. Offers information on the agency and its programs and activities.

FAMILY Life Information Exchange, P.O. Box 10716, Rockville, MD 20850; (301)770-3662. Collects, produces, and distributes materials on family planning, adolescent pregnancy, and adoption; also makes referrals to other information centers. Primary audiences are programs funded through both Title X (National Family Planning Clinics) and Title XX (Adolescent Family Life Program) of the Public Health Service Act.

FOOD AND DRUG Administration, Office of Consumer Affairs, 5600 Fishers Lane, HFE-88, Rockville, MD 20857; (301)443-3170. Answers consumer inquiries and serves as a clearinghouse for the FDA's consumer publications.

FOOD AND NUTRITION Information Center, National Agricultural Library, Room 304, Beltsville, MD 20705; (301)344-3719. Serves the information needs of professionals, students, and consumers interested in nutrition education, nutrition science, food service management, food science, and food technology. Students and consumers are encouraged to contact local resources such as their local cooperative extension agency, health departments, and public and university libraries before calling the center. Acquires and lends books, journal articles, and audiovisual materials dealing with these areas. Call the center to ensure lending eligibility. Functions as a software demonstration center on nutrition-related software. Anyone is welcome to visit the center to experiment with the software, by appointment only.

Clearinghouse on the HANDICAPPED, Switzer Building, Room 3132, 330 C Street, S.W., Washington, DC 20202; (202)732-1244. Responds to inquiries by referral to organizations that supply information to handicapped individuals relating to their own disabilities. Provides information on Federal benefits, funding, and legislation for the handicapped.

National Information Center for Children and Youth With HANDICAPS, P.O. Box 1492, Washington, DC 20013; (703)893-6061. Helps parents of handicapped children, disabled adults, and professionals locate services for the handicapped and information on disabling conditions.

Clearinghouse on HEALTH INDEXES, National Center for Health Statistics, Office of Analysis and Epidemiology Programs, 3700 East-West Highway, Room 2-27, Hyattsville, MD 20782; (301)436-7035. Provides information to assist in the development of health and quality of life measures for health researchers, administrators, and planners.

ODPHP National HEALTH INFORMATION Center, P.O. Box 1133, Washington, DC 20013-1133; (800)336-4797; (301)565-4167 (MD only). Helps the public locate health information through identification of health information resources and an inquiry and referral system. The center, formerly the National Health Information Clearinghouse, refers questions to appropriate resources that, in turn, respond directly to inquiries. Prepares and distributes publications and directories on health promotion and disease prevention topics.

Combined HEALTH INFORMATION DATABASE, (CHID), National Diabetes Information Clearinghouse, Box NDIC, Bethesda, MD 20892; (301)468-2162. Provides health information and information on health education/health promotion resources to professionals. The on-line, publicly accessible database includes sub-files of nine information programs: AIDS school health education, arthritis, diabetes, digestive diseases, health education, health information, high blood pressure, kidney diseases, and Veterans Administration education. The database is available on-line through BRS Information Technology; call (800)345-4277.

National HIGH BLOOD PRESSURE Education Program Information Center, 4733 Bethesda Avenue, Room 530, Bethesda, MD 20814; (301)951-3260. Provides information on the detection, diagnosis, and management of high blood pressure to consumers and health professionals.

National HIGHWAY TRAFFIC SAFETY Administration, NES-11 HL, U.S. Department of Transportation, 400 7th Street, S.W., Washington, DC 20590; (202)366-9294; Auto Hotline: (800)424-9393; (202)366-0123 (DC Metro area). Works to reduce highway traffic deaths and injuries. Publishes a variety of safety information brochures, conducts public education programs that promote the use of safety belts and child safety seats, and informs the public of the hazards of drunk driving. Maintains a toll-free Hotline for consumer complaints on auto safety and child safety seats and requests for information on safety manufacturing flaws and recalls by specific year, make, and model. Complaint forms will be mailed upon request.

HUD User (HOUSING), P.O. Box 280, Germantown, MD 20874-0280; (800)245-2691; (301)251-5154 (MD only). Disseminates the results of research sponsored by the U.S. Department of Housing and Urban Development. Health-related topics included in the database are housing safety, housing for the elderly and handicapped, and hazards of lead-based paint. There is a fee for publications.

Project Share (HUMAN SERVICES), P.O. Box 2309, Rockville, MD 20852; (800)537-3788; (301)231-9539 (MD only). Provides reference and referral services designed to improve the management of human services by emphasizing the integration of those services at the delivery level, with special emphasis on youth-related issues through the Share Resource Center on Teen Pregnancy Prevention. There is a fee for some publications. Project Share also maintains a database of over 14,000 documents on human services; a custom search is available for $15.

National INJURY Information Clearinghouse, 5401 Westbard Avenue, Room 625, Washington, DC 20207; (301)492-6242. Collects and disseminates injury data and information relating to the causes and prevention of death, injury, and illness associated with consumer products. Requests for general safety information are referred to the Consumer Product Safety Commission.

National KIDNEY and Urologic Diseases Information Clearinghouse, Box NKUDIC, Bethesda, MD 20892; (301)468-6345. Collects and disseminates information on patient education materials. Maintains kidney and urologic diseases sub-file of the Combined Health Information Database. Responds to public inquiries from consumers and health professionals.

National Center for Education in MATERNAL AND CHILD HEALTH, 38th and 8 Streets, N.W., Washington, DC 20057; (202)625-8400. Answers requests from health care professionals and the public in all areas relating to maternal and child health. Produces bibliographies, resource guides, and directories. Maintains a resource center that is open to the public by appointment.

National MATERNAL AND CHILD HEALTH Clearinghouse, 38th and 8 Streets, N.W., Washington, DC 20057; (202)625-8410. Distributes publications on maternal and child health to consumers and health professionals.

National Institute of MENTAL HEALTH, Public Inquiries Branch, Parklawn Buildings, Room 15C-05, 5600 Fishers Lane, Rockville, MD 20857; (301)443-4518. Distributes Institute publications and provides information and publications on the Depression/Awareness, Recognition, and Treatment program (D/ART). This is a national program to educate the public, primary care physicians, and mental health specialists about depressive disorders and their symptoms and treatments. D/ART is sponsored by the National Institute of Mental Health in collaboration with the private sector.

Office of MINORITY HEALTH Resource Center, P.O. Box 37337, Washington, DC 20013-7337; (800)444-6472; (301)587-1983. Responds to consumer and professional inquiries in minority health-related topics by distributing materials, providing referrals to appropriate sources, and identifying sources of technical assistance. Coordinates a network of professionals active in the field of minority health and related areas. Operates a toll-free telephone number accessible to the 50 states, the District of Columbia, and Puerto Rico.

Clearinghouse for OCCUPATIONAL SAFETY and Health Information, Technical Information Branch, 4676 Columbia Parkway, Cincinnati, OH 45226; (800)35-NIOSH. Provides technical support for National Institute for Occupational Safety and Health research programs and supplies information to others on request.

National Information Center for ORPHAN DRUGS and Rare Diseases, P.O. Box 1133, Washington, DC 20013-1133; (800)336-4797; (301)565-4167 (MD only). Gathers and disseminates information on orphan products and rare diseases. Responds to inquiries from patients, health professionals, and the general public.

President's Council on PHYSICAL FITNESS and Sports, 450 5th Street, N.W., Suite 7103, Washington, DC 20001; (202)272-3430. Produces informational materials on exercise, school physical education programs, sports, and physical fitness for youth, adults, and the elderly. Sponsors the Presidential Physical Fitness Awards Program, which recognizes students who achieve standards on five fitness tests.

National Clearinghouse for PRIMARY CARE Information, 8201 Greensboro Drive, Suite 600, McLean, VA 22102; (703)821-8955. Provides information services to support the planning, development, and delivery of ambulatory health care to urban and rural areas where there are shortages of medical personnel and services. Although the clearinghouse will respond to public inquiries, its primary audience is health care providers who work in community health centers.

Consumer PRODUCT SAFETY Commission, Washington, DC 20207; (800)638-2772. Evaluates the safety of products sold to the public. Provides printed materials on different aspects of consumer product safety on request. Does not answer consumer questions on boats, cars, cosmetics, drugs, food, prescriptions, warranties, advertising, information on car recalls, repairs, maintenance, or medical devices.

National REHABILITATION Information Center, 8455 Colesville Road, Suite 935, Silver Springs, MD 20910; (301)588-9284 (MD only); (800)346-2742 (voice and TDD). Provides information on disability-related research, resources, and products for independent living. Provides fact sheets, resource guides and research and technical publications.

Office on SMOKING and Health, Technical Information Center, Park Building, Room 1-16, 5600 Fishers Lane, Rockville, MD 20857; (301)443-1690. Offers bibliographic and reference services to researchers and others and publishes and distributes a number of publications in the field of smoking.

SUDDEN INFANT DEATH Syndrome Clearinghouse, 8201 Greensboro Drive, Suite 600, McLean, VA 22102; (703)821-8955. Provides information and referrals on SIDS, apnea, grief, and bereavement for parents and families and health professionals.

National Second SURGICAL OPINION Program; (800)638-6833; (800)492-6603 (MD only). Provides information for people faced with the possibility of non-emergency surgery. Sponsors a toll-free telephone number to assist the public in locating a surgeon or other specialist.

Association for the Advancement of Health Education
1900 Association Drive, Reston, VA 22091
(703) 476-3481

Selected publications

- Health Education Journal (published bimonthly) • The Drug Alterative • HEALTH Education Teaching Ideas: Elementary • Health Education Teaching Ideas: Secondary • Managing Teacher Stress and Burnout • Microcomputers and Health Education • Who Teaches Health?

American School Health Association
Kent, OH 44240
(216) 678-1601

Selected publications

- Journal of School Health (published ten times per year) • A Healthy Child: The Key to the Basics • Health Instruction: Guidelines for Planning Health Education Programs, K-12 • Mental Health in the Classroom

National Center for Health Education
30 East 29th Street
New York, NY 10016
(212) 689-1886

Selected publications

- CENTER Journal (published five times per year) • Education for Health: The Selection Guide (Note: Each CESA human growth and development coordinator has a copy of this guide.)
- Growing Healthy: Comprehensive Education-for-Health, Grades K-7

American Medical Association
Department of Health Education
535 North Dearborn Street
Chicago, IL 60610
(312) 751-6000

Selected publications

- Physician's Guide to the School Health Curriculum Process • Why Health Education in Your School?

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The "Health Enhancement Curriculum" outlined in the following pages is the result of the work done by the Health and Physical Education Committee created by Project Excellence. Project Excellence was an almost two-year-long process designed to revise Montana's Accreditation Standards in line with the educational needs of students into the next century. Committees were formed to look at the needs for each curricular area. The work of these committees included "learner outcomes" for each program area at the primary, intermediate and graduation levels. The Health and Physical Education Committee of Project Excellence developed a unique plan by combining the learner outcomes under the umbrella term "health enhancement." The rationale and philosophy for doing this are found in this document and provide a new way of thinking about traditional programs in health and physical education.

School districts, in undertaking curriculum development in health enhancement, should keep in mind the major goals of the Health Enhancement Program:

(a) Integrate lifestyle management throughout the curriculum;
(b) Focus on the total self and the development of self-responsibility, values, attitudes and behaviors;
(c) Give students decision-making tools for personal health; and
(d) Address intellectual, social, emotional, and physical dimensions of healthy lifestyles.

Examples of specific learner outcomes for each of the three levels are found in this booklet, as well as the Montana School Accreditation Standards and Procedures Manual.

Board of Public Education
State of Montana

School districts are required to institute a plan of curriculum development that will reflect the program area standards and includes local learner outcomes starting not later than 1991. In addition, curricula must be reviewed at intervals not exceeding five years.

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The model for the development, implementation, and evaluation of the Health Enhancement Program (HEP) presented represents a conceptual framework for the institutionalization and continual refinement of HEPs in public schools. It recognizes the initiation of Project Excellence by the Board of Public Education of the state of Montana (1987) and the various inputs of professional bodies and citizens concerned about the future of education in Montana.

The school accreditation standards developed by the Action Groups of Project Excellence and modified by the Board of Public Education directly affect the subsequent preparation of teachers in the colleges and universities and the development, implementation and evaluation of the HEPs in the public schools. Since the curriculum developed for an individual school is intended to reflect the issues and concerns of the community in which the school operates, the inputs of local health professionals and the local school board are seen as important elements in this process. The regular evaluation of the HEPs through internal process in the school and through regular evaluation from the Office of Public Instruction provides direct means by which HEPs can be monitored and continually refined.

The transition from the present Health and Physical Education standards to the new Health Enhancement Program standards will require a systematic inservice program for teachers in the public schools and for local communities. This inservice will be necessary for two reasons:

(l) to facilitate a shift from a traditional Health and Physical Education curriculum to a holistic approach through health enhancement; and

(2) to facilitate the shift from a time/unit accreditation model to a learner outcome accreditation model.

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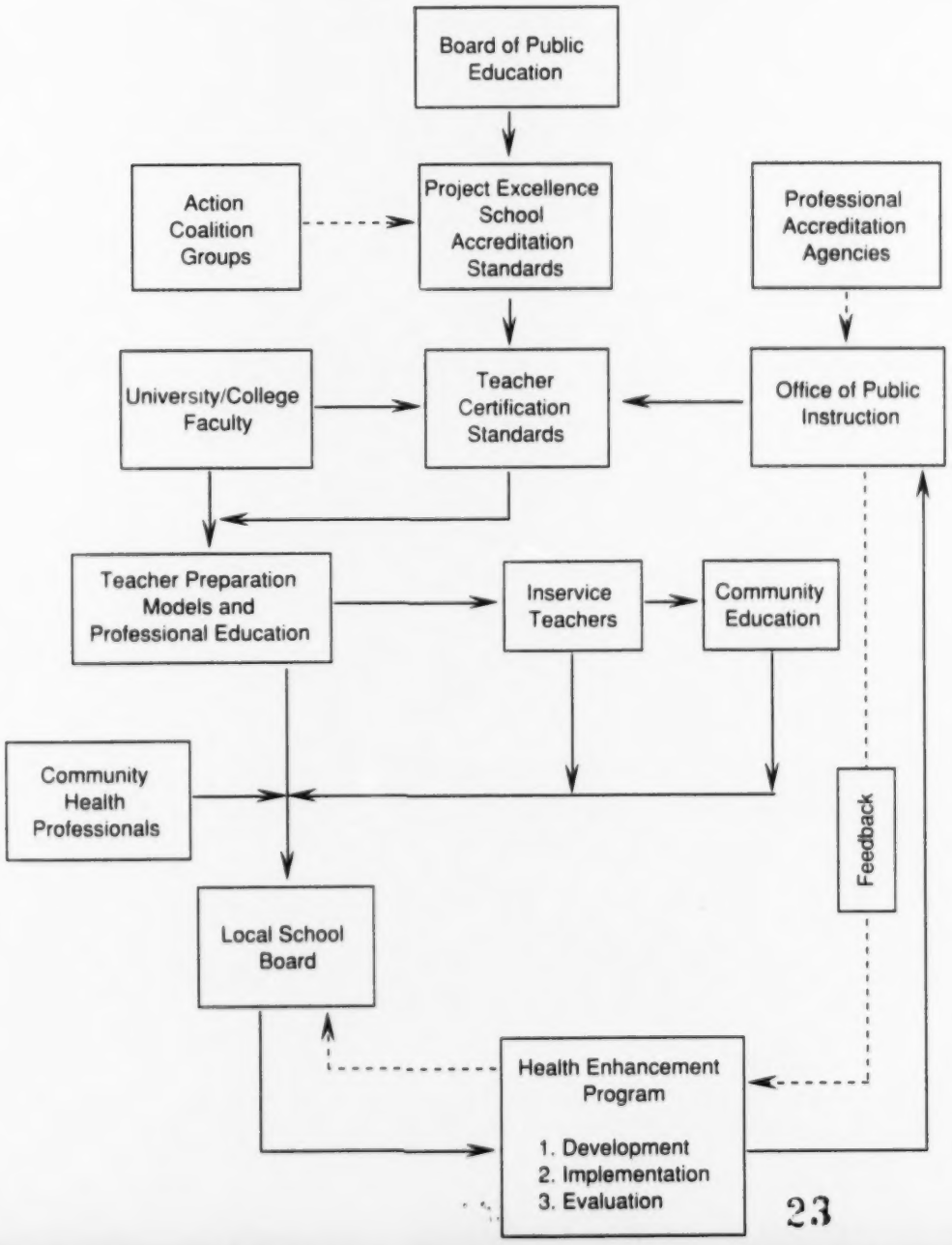
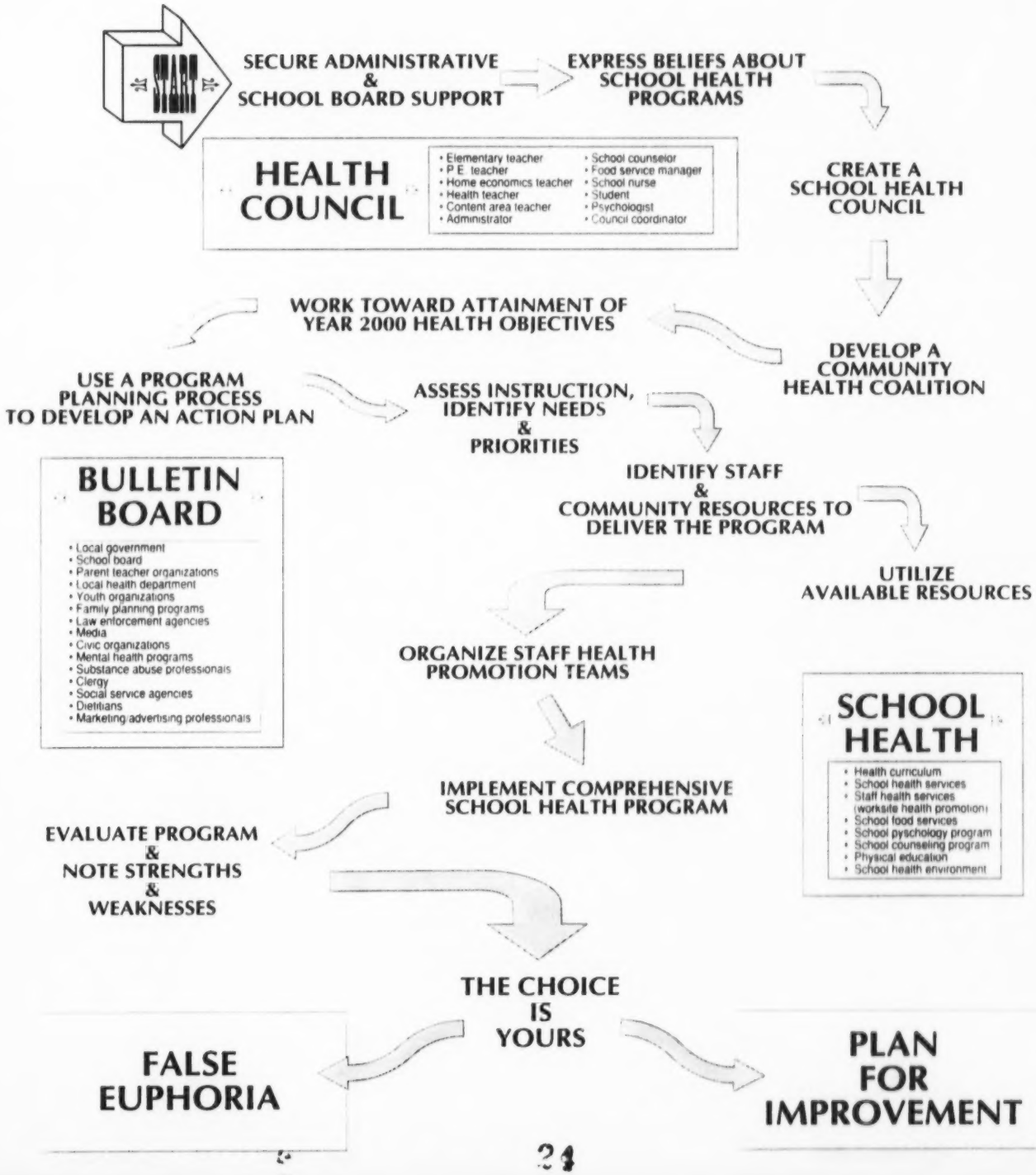
Conceptual Model for the Development, Implementation and On-Going Evaluation of the Health Enhancement Program.




START
SECURE ADMINISTRATIVE & SCHOOL BOARD SUPPORT
EXPRESS BELIEFS ABOUT SCHOOL HEALTH PROGRAMS
HEALTH COUNCIL
• Elementary teacher
• P.E. teacher
• Home economics teacher
• Health teacher
• Content area teacher
• Administrator
• School counselor
• Food service manager
• School nurse
• Student
• Psychologist
• Council coordinator
CREATE A SCHOOL HEALTH COUNCIL
DEVELOP A COMMUNITY HEALTH COALITION
WORK TOWARD ATTAINMENT OF YEAR 2000 HEALTH OBJECTIVES
USE A PROGRAM PLANNING PROCESS TO DEVELOP AN ACTION PLAN
ASSESS INSTRUCTION, IDENTIFY NEEDS & PRIORITIES
BULLETIN BOARD
• Local government
• School board
• Parent teacher organizations
• Local health department
• Youth organizations
• Family planning programs
• Law enforcement agencies
• Media
• Civic organizations
• Mental health programs
• Substance abuse professionals
• Clergy
• Social service agencies
• Dietitians
• Marketing/advertising professionals
IDENTIFY STAFF & COMMUNITY RESOURCES TO DELIVER THE PROGRAM
UTILIZE AVAILABLE RESOURCES
ORGANIZE STAFF HEALTH PROMOTION TEAMS
SCHOOL HEALTH
• Health curriculum
• School health services
• Staff health services (worksite health promotion)
• School food services
• School pyschology program
• School counseling program
• Physical education
• School health environment
IMPLEMENT COMPREHENSIVE SCHOOL HEALTH PROGRAM
EVALUATE PROGRAM & NOTE STRENGTHS & WEAKNESSES
THE CHOICE IS YOURS
FALSE EUPHORIA
PLAN FOR IMPROVEMENT

Information contained in this section is taken from a report produced in March 1990 titled, "Montana Adolescent Health Status," produced through the cooperative effort of the Office of Public Instruction, Department of Health and Environmental Sciences and Montana Coalition of Healthy Mothers, Healthy Babies.

Montana's young people are a treasured natural resource whose health, education, and well-being are vital concerns of family, school personnel, and members of the community. The common concern over the health of our adolescents is based on the knowledge that youth are at risk for certain diseases, accidents, and trauma because of their inherent vulnerability. In addition, in their formative years, they are making personal choices about behaviors which can have lifelong effects on their health. Although all youth do not exhibit unhealthy behaviors, it is necessary to identify potential unhealthy behaviors to ensure that appropriate prevention methods are addressed by families, schools, and the community.

Montana's young people are a treasured natural resource whose health, education, and well-being are vital concerns of family, school personnel, and members of the community.

Today, death and disability among Montana's young people increasingly stem from lifestyles and environmental conditions which cause stress, anxiety, depression, and low self-esteem. These complex expressions of psychosocial discontent often lead to self-destructive or health-threatening behaviors such as drug and alcohol abuse, teenage pregnancy, eating disorders, risk taking, and hostility toward parents, teachers, and society. Because it is apparent that unhealthy social behaviors are the primary threats to the health and well-being of adolescents, effective prevention and intervention strategies need to be developed.

In order to initiate appropriate prevention and intervention, the sources of at-risk behaviors and health-related problems must be identified before effective remedial actions can be taken. Cultural attitudes, gender-specific patterns of behavior, and age/development-related patterns of behavior must be identified and evaluated. Precautionary efforts need to focus on the range and patterns of motivations and behavior practices.

Intervention and prevention are often most successful if initiated prior to when adolescents actually engage in unhealthy practices. The use of tobacco and alcohol begins with many youth prior to the 7th grade; therefore, prevention efforts need to start in the early years and continue through grade 12. The program should be age and developmentally appropriate, research based, and sensitive to the values and needs of the community.

Identifying the source of adolescents' health-related problems can be extremely complex and can have origins in the family environment. Suicide attempts, for example, are strongly related to low self-esteem, emotional distress, and antisocial behavior. Suicide, however, also can be related to family history of drug and alcohol abuse, physical violence, or sexual abuse. Prevention must reflect awareness that parents may be an integral part of the problem and must be able to assist adolescents whose parents are unwilling or unable to become involved.

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Injury prone and risk-taking behaviors may be motivated by the desire to get high or to have fun in combination with the attempt to escape problems. Different prevention strategies are required to discourage risk taking for thrills as opposed to risk taking to escape problems.

The following information is taken from the 1990 Montana Adolescent Health Status Report, the National Adolescent Student Health Survey of 1987, and "Facts at a Glance," produced by the Montana Coalition of Healthy Mothers, Healthy Babies.

Motor vehicle crashes are the leading cause of death among Americans in the 1 to 34 age group. In response to the risk of accidental death and injury in automobile accidents, the Montana Legislature passed Montana's Safety Belt Use Act in 1987. This law requires that drivers and passengers wear seat belts while traveling in motor vehicles. Seat belt use can reduce the number of serious injuries by 50 percent and fatalities by 40 to 60 percent. In spite of the fact that seat belt use saves 40 to 80 lives annually and prevents 700 injuries each year in Montana, some people, in violation of the law and at greater personal risk, refuse or neglect to buckle up.

Wearing helmets while riding motorcycles or bicycles reduces the risk of sustaining serious or fatal head injuries resulting from accidents. Studies of motorcycle accidents in states which do not require helmet use revealed that accidents resulted in three times as many fatal or serious head injuries as compared with states that require safety helmet use. Death or disability resulting from accidents not only affects the victim, but also has economic, social, and psychological costs for family members and society as a whole.

- Almost half of Montana's twelfth grade students rarely or never wear a seat belt while riding in or driving a motor vehicle.
- In general, Montana adolescents are not wearing safety helmets when riding a bicycle.
- About half of Montana's adolescents wear a safety helmet when riding a motorcycle.
- Accidents remain the leading cause of death for Montana's school-age children.

During adolescence, growth and development accelerate leading to dramatic physical increases in height, weight, development of organs, and sexual maturation. Adequate nutrition is essential for normal development during adolescence and for long-term health in adults. Nutritional and dietary deficiencies have been linked to infant mortality, tooth decay, obesity, anemia, and retarded mental development in children and adults.

In general, diseases resulting from nutritional deficiencies have diminished; however, they have been replaced by diseases of dietary excess and imbalance. Disproportionate consumption of foods high in fats, often at the expense of foods high in complex carbohydrates and fiber, are typical eating patterns of adolescents.

- An estimated 37,000 Montana school-age children may have weight-related problems from obesity.
- Estimates for Montana are that anorexia has a potential for affecting approximately 390 girls with an estimated 58-80 deaths from this group.

[redacted]

Suicide was the second leading cause of death of Montana youth in 1987. Nationwide, an average of 18 young people between the ages of 14 and 24 kill themselves each day and 57 youth attempt suicide each hour in the United States. Between 1960 and 1985, the suicide rate for the age group 14 to 24 rose 300 percent, while the rate for other age groups rose less than 20 percent.

Suicide involves complex behaviors that result from psychological or social pressures that may be difficult to detect and understand; however, suicidal behaviors can be diagnosed, treated, and prevented as more information becomes available and timely and appropriate interventions are implemented.

Suicide was the second leading cause of death of Montana youth in 1987. Nationwide, an average of 18 young people between the ages of 14 and 24 kill themselves each day.

- In Montana, attempts of suicide are higher for females than male adolescents.
- For Montana youth, 9 percent of male adolescents reported attempting to commit suicide as compared to 18 percent of female adolescents.
- Nationally, the suicide rate has tripled over the past 30 years, and the suicide rate for adolescent males increased nearly 50 percent between 1970 and 1980.
- Montana ranks fourth in the nation for adolescent suicide rate.

[redacted]

The 1989 Report of the U.S. Surgeon General confirmed that cigarette smoking remains the single most preventable cause of death and disability from cancer and other diseases. Smoking is responsible for more than one of every six deaths. Smokers have a 50 to 100 percent greater chance of heart attack than non-smokers and heart attacks are more severe when they occur. The national average death rate for heavy smokers between the ages of 25 and 63 is double that of non-smokers. Smokeless tobacco increases the risk of gum disease, tooth loss, and cancers of the mouth, cheek, and gums. In spite of widespread education, publicity, and warning of tobacco products, adolescents in Montana continue to experiment with the use of tobacco on a regular basis. Each day more than 3,000 American teenagers start smoking.

Alcohol, the major drug of choice for all grade levels and both sexes in Montana, appears to be widely available in the state. Although there has been considerable information in the news media that drinking and driving greatly increase the risk of accidental death or injury in automobile accidents, many Montana youth drink and drive or ride with a driver who has consumed alcohol. Driving after drinking alcohol not only threatens the driver and passenger, but also jeopardizes the safety of other drivers, passengers, and pedestrians.

25 percent of sexually active twelfth graders reported that they rarely or never use birth control methods.

Drug use among Montana twelfth grade youth is lower than the national average; however, it is a major problem throughout the state. The use of drugs such as marijuana, hashish, and cocaine indicates that drugs common in larger metropolitan areas are also available in Montana.

- The percentage of Montana twelfth grade youth who have tried smokeless tobacco products is well above the national average.
- Nationally, one out of every five adolescents smoked cigarettes during the past month.
- 95 percent of Montana's twelfth grade students have drunk an alcoholic beverage.
- Montana surveyed students reported that they first drank an alcoholic beverage at grade six or earlier. Peak experimental usage occurred in grades 7, 8 and 9.
- Almost one-quarter of Montana surveyed adolescents worry about the amount of alcohol that their parents drink.
- Nationally, more than one-fourth of adolescents report one occasion of heavy drinking during the past two weeks. About one out of every 10 adolescents smoked marijuana in the past month. About one out of every 15 adolescents have tried cocaine. About one out of every five adolescents have tried sniffing glue.

Effective sexuality education is more than instruction in reproduction and anatomy. It includes issues such as self-esteem, decision-making, goal setting, family values, peer relationships, and dating. A study conducted in Baltimore with junior high students found that students who were in sexuality education classes and who had access to birth control services postponed their first sexual activity.

Research also has demonstrated that family involvement in sexuality education efforts along with school and community support is necessary for effective sexuality education. Public support for sexuality education is high, but there are differing opinions as to where and when it should be introduced and as to what institution should provide the instruction. There is also disagreement on what the curriculum should include.

Two-thirds of the total number of gonorrhea and syphilis cases occur in people under the age of 25. Sexually active women under 20 years of age have chlamydia infection rates two to three times higher than women over 20 years of age. Similarly, the rates of urethral infection among young men are higher

than for older men. Because of the known association with human papillomavirus, cervical cancer now is considered a sexually transmitted disease, related to the age at first intercourse and number of sexual partners. These problems can be prevented by sexual abstinence or condom use.

- Approximately 70 percent of Montana's twelfth grade students have had sexual intercourse. One-half of the twelfth graders who reported having sexual intercourse had engaged in sex by age 15. As adolescents grow older, their approval of sexual intercourse before marriage grows stronger.
- Nationally, the average age for a girl to have sexual intercourse for the first time is 16.2 years; for a boy it is 15.7 years.
- In Montana in 1988, there were 1,818 teen pregnancies. Of these pregnancies, 36 percent resulted in abortions; 44 percent resulted in out-of-wedlock births.
- One in four teen mothers will get pregnant again within 18 months.
- Children and siblings of teen mothers often repeat the pattern of early childbearing themselves. There is also growing evidence that these children have a higher incidence of substance abuse, delinquency, and dropping out of school.
- Nationally, it is estimated that 2.5 million teenagers are infected with sexually transmitted diseases (STD) each year.

[redacted]

Sexual abuse of youth is becoming better known with increased state legislation on reporting requirements for health and human services workers. Physical or sexual abuse in a child's life is often the precursor for other high-risk or dysfunctional behavior later in life. Early sexual activity, eating disorders, inappropriate social interactions, and other problems can follow a history of sexual abuse. It is estimated that 30 percent of those who were physically or sexually abused or extremely neglected as children become abusive parents themselves.

According to Montana law (45-5-501, 503, and 505), a person can be convicted of "sexual intercourse without consent" if the victim is less than 16 years old and the offender is three or more years older than the victim. The law further states that anyone under the age of 16 is incapable of consent.

- 26 percent of twelfth grade female students reported that they have been sexually abused (i.e., touched in inappropriate places or had sexual acts when they did not want to), as compared to 4 percent of twelfth grade males.
- 61 percent of twelfth grade students who have been sexually abused have discussed the incident with another person.
- 12 percent of the female students surveyed reported having sexual intercourse with a partner three or more years older than themselves.

Teenage pregnancy may pose emotional trauma, often limits educational attainment, or may force young parents to abandon future plans and aspirations. Many pregnant teenagers are victims of neglect or abuse and are not prepared emotionally to become mothers. Young mothers often look to their babies to provide them with the love, care, and security which they never had. Children of teen mothers often repeat the pattern of early child-bearing.

In 1988, there were 1,818 teenage pregnancies in Montana, with 36 percent resulting in abortion and 44 percent resulting in out-of-wedlock births. The number of out-of-wedlock births in Montana has nearly doubled over the last 15 years.

- 15 percent of sexually active twelfth grade female students have been pregnant at least once, while 11 percent of twelfth grade male students reported having impregnated at least once in their lifetime.
- 25 percent of sexually active twelfth graders reported that they rarely or never use birth control methods.
- Obtaining birth control products does not appear to pose a problem for twelfth grade students, with 69 percent reporting that they would have no difficulty in obtaining birth control products in their community.
- Of the sexually active twelfth grade adolescents who use birth control, condoms and birth control pills are the most common methods used.
- A history of multiple sexual partners increases the risk of contracting Acquired Immune Deficiency Syndrome (AIDS). This risk is further increased with inconsistent condom use and unplanned sexual activity. Nationally, 20 percent of the reported AIDS cases among men and 25 percent of the reported AIDS cases among women occurred between 20 and 29 years of age. With the AIDS virus having an incubation period of 7 to 8 years, these statistics indicate that many individuals with AIDS were infected with the virus as teenagers.

Historically, the school health program has been comprised of three components: health education, school services, and the school environment.

In recent years, comprehensive health education has evolved to include eight distinct components which impact health-related behaviors of students, as well as staff and faculty wellness. These health behaviors, in turn, have an impact on individual health status and educational achievement. In addition, health education programs help students learn self-responsibility, decision-making, problem-solving, refusal skills, and other skills which apply to academic achievement and daily living.

The following is an excerpt from an article that appeared in the *Journal of School Health*, Vol. 57, No. 10, in December 1987, PP. 409-412. The article titled "The Comprehensive School Health Program Exploring an Expanded Concept," Allensworth, D.D. and Kolbe, L.J., is copyrighted by the American School Health Association, P.O. Box 708, Kent, OH, 44240 and is reprinted, in part, with permission.

Promoting the health of the school-age child is no easy task. It cannot effectively be accomplished through the singular efforts of an individual, a school, or an agency. Often these groups find themselves duplicating services and competing with each other while working toward a similar goal. What is needed to serve the public effectively is sympathetic cooperation...

Since the early 1900s, the school health program has been conceived to include three components: school health services, school health education, and the school health environment. During the past several decades, society has evolved rapidly. Health problems have changed. So have schools and students.

In the early 1900s, the major causes of morbidity and mortality largely were infectious agents; today the major causes largely are behaviors. At the end of World War II, the average school district served 250 students; today it serves 2,500. Students today also are different. Three-quarters of youth now live in urban areas, one-half of them will spend some part of their childhood with only one parent, more than one-half will have used an illegal drug before graduating from high school, and more than one-half will have engaged in non-marital sexual intercourse by the time they are 18.

Nevertheless, the future of young people may be brighter than ever before. As the current leading causes of morbidity and mortality emerged, such as cardiovascular disease, cancer, and motor vehicle crashes, health professionals have learned how to diagnose and treat them more effectively. They have learned how behaviors such as tobacco use, consumption of saturated and total fat, failure to use safety belts, contributed to them, and we have learned how to help others avoid behaviors that are pathogenic and adopt behaviors that improve health. We also have

> What is very clear is that education and health of our children are inextricably intertwined. A student who is not healthy, who suffers from an undetected vision or hearing defect, or who is hungry, or who is impaired by drugs or alcohol, is not a student who will profit from the educational process. Likewise, an individual who has not been provided assistance in the shaping of healthy attitudes, beliefs, and habits early in life, will be more likely to suffer the consequences of reduced productivity in later years.

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learned how health, and certain health-related behaviors, contribute to cognitive performance and educational achievement. As Michael McGinnis, MD, Director, U.S. Office of Disease Prevention, Retention and Health Promotion, U.S. Dept. of Health and Human Services, has noted:[2]

Schools could do more perhaps than any other single agency in society to help young people, and the adults they will become, to live healthier, longer, more satisfying, and more productive lives. Indeed, more education and health professionals are becoming interested and involved in working with schools to protect and improve the health of students, and to protect and improve the health of school personnel as well. Consequently, the purpose of this special issue of the *Journal of School Health* is to explore whether the concept of the comprehensive school health program should be expanded to include not only school health services, school health education, and the school health environment, as well as integrated efforts of school and community agencies to improve the health of students, the school physical education program, the school food service program, the school counseling and psychology program, and school programs to protect and improve the health of faculty and staff.

The comprehensive health education program comprises a planned sequential pre-kindergarten–12 curriculum that addresses the physical, mental, emotional, and social dimensions of health.

As depicted in Figure I, these eight components of a comprehensive school health program, if coordinated to address a given health behavior or health problem, could have complementary if not synergistic effects. It is assumed, for example, that nutrition education would be far more effective in reducing dietary risks for cardiovascular disease and cancer if the school food service program concomitantly reduced the availability of foods that increased such risk, and replaced them with other foods students like, and if they provided supplemental nutrition education within the cafeteria.

In some conceptualizations of the comprehensive school health program, the school food service is considered to be part of the school health environment. If the school food service were considered a distinct component of the comprehensive school health program, however, it would be possible to more effectively illuminate and clarify the effects of the school food service on the health and health behaviors of students, and might enable and motivate more school food service professionals to work as a full team member in planning and implementing the comprehensive school health program. Similarly, agencies and professional organizations that support school food service programs also may become more interested in working jointly with agencies and professional organizations that support the other seven components to help coordinate and improve comprehensive school health programs.

An overview of the eight components, and the articles that comprise this special issue follow.

The comprehensive *health education program* comprises a planned sequential pre-kindergarten - 12 curriculum that addresses the physical, mental, emotional, and social dimensions of health. The curriculum is designed to motivate and enable students to maintain and improve their health and not merely to prevent disease. The health education program is integrated with the other seven components of the school health program, and provides opportunities for stu-

dents to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices.

School health service programs promote the health of students through prevention, case finding, early intervention, and remediation of specific health problems, provision of first aid and triage of illness and injuries, provision of direct services for handicapped students, and provision of health counseling and health instruction for faculty, staff, and students. Professionally prepared school nurses most often coordinate and provide the health services program. However, there are other professionals who provide specific services to promote the health and well-being of the school-age child, including school physicians, dentists, social workers, and speech pathologists.

A school health environment includes the psychological climate and physical surroundings in which students and school personnel are expected to work. Factors that contribute to the physical environment include the school and location and the area that surrounds it, and the school building, including biological or chemical agents that may be detrimental to health, and physical conditions such as temperature, humidity, electromagnetic radiation, mechanical vibration, noise, lighting, and heat. The psychological environment comprises the interrelated physical, emotional, and social conditions that affect the well-being and productivity of students and school personnel. The nature of the school environment often is established by formal and informal administrative policies. Those responsible for the school environment must address safety needs (reduce potential hazards including physical or psychological abuse), social needs (facilitate establishment of positive relationships), and recognition needs (recognize the worth and success of individuals and facilitate the establishment of self-esteem for students and school personnel).

Physical education can serve as a means for maintaining cardiovascular and respiratory efficiency, for self-expression and social development, as a relief for stress, and as a means for providing meaning to movement in the life of a child. Physical education programs can improve motor performance (endurance, strength, agility, balance, speed, and possibly flexibility), physiologic and metabolic functions, aerobic capacity, frequency and duration of exercise, and cognitive performance.

Though the school counseling program originally was implemented to provide vocational guidance for students, by the mid-1960s, the program had evolved to also provide developmental guidance. Counselors provide broad-based intervention programs to promote the physical and emotional health of students. Interventions include assertiveness training, life skills training, peer led discussions, problem-solving training, and programs to address esteem, loss of control, peer pressure and adolescent rebellion.

The *school psychology* program provides psychological assessment, consultations, and interventions to improve the performance and adjustment of students. The role and function of the psychologist varies greatly among states and among schools within a state. The school psychologist conducts psycho-educational evaluations and recommends educational and other interventions for students with perceived learning, behavioral, or emotional problems. A significant portion of the school psychologist's time is devoted to implementing.

Public Law 94-142, the Education for all Handicapped Children Act, which requires schools to identify, assess, provide educational prescriptions for, and subsequently, reevaluate students who may have handicaps that retard learning. As an applied be-

havioral scientist in the school setting, school psychologists increasingly are being asked to help address health problems. Currently, the nation's *school-food service* programs provide 27 million lunches and 3 million breakfasts daily. In addition to providing one-third to one-half of the daily nutritional intake for many of American students, the food service program supports a nutrition education program to help students learn how to select nutritionally appropriate foods. Schools are ideal settings for *work site health promotion* programs because they already have the facilities and professional resources required to develop and implement the program, including pupil service professionals (school nurses, counselors, and psychologists), the food service staff, as well as health education, physical education, and home economics teachers. Furthermore, the benefits of a school site wellness program may have a multiplier effect.

Staff who become interested and active in maintaining and improving their own health may become more interested and active in improving the health of students and may provide powerful role models. School site health promotion programs for faculty and staff can provide economic benefits for the district and can improve the productivity of school personnel. They have been shown to reduce weight, body fat, systolic and diastolic blood pressure, anxiety, depression and smoking, and to increase exercise and consumption of a more balanced diet. School site health promotion programs have decreased absenteeism, health care claim costs, the need for substitute teachers, and have improved teacher morale and productivity. The need for an integrated school and community approach is being rediscovered as an effective strategy to promote the well-being of children and youth. Currently, collaborative efforts among health and education professionals not only include school health advisory councils, but coalitions that coordinate and advocate improving the various components of the comprehensive school health program. Coalitions can provide active and broadly based constituencies to support and improve school health programs and have been used successfully to promote implementation of specific health curriculum and school-based clinics.

School Health Promotion Components and Outcomes

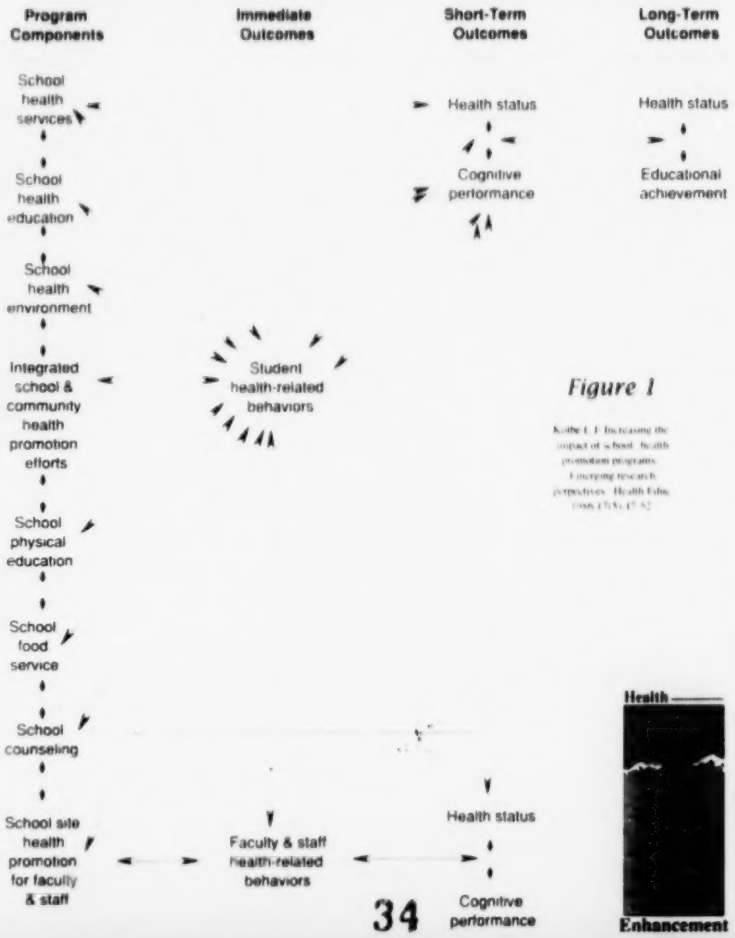

Figure 1

Kolbe L J. Increasing the impact of school health promotion programs: Emerging research perspectives. Health Educ. 1986;17(5):47-52.

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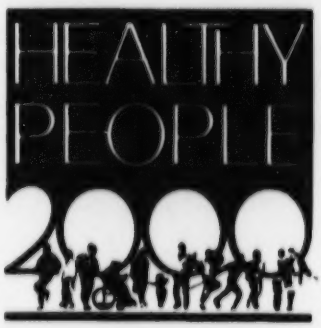
Objectives

PROMOTING THE HEALTH OF CHILDREN AND YOUTH THROUGH PRIMARY AND SECONDARY SCHOOLS

The schools have historically and traditionally been an avenue to target to reduce premature death, disease and disability. In the "1990 Health Objectives for the Nation," over 75 percent of the health objectives for the nation had direct relevance to improving the health of children and adolescents.



National Health Promotion and Disease Prevention Objectives

Montana youth continue to die at unacceptable rates from preventable causes of death — unintentional injuries, suicides, and homicides. Too many of our youth suffer from disabling conditions caused by motor vehicle accidents, falls, drowning, poisoning, teenage pregnancy, child abuse, drug and alcohol abuse, mental problems, and smoking. Most of these tragic losses of life and health are preventable.

The Year 2000 Objectives offer schools the opportunity to team together with schools throughout the nation on common objectives. The objectives provide measurable terms which increase emphasis on reducing preventable morbidity and disability, reducing health disparities between population groups, and improving the quality and quantity of life.

Year 2000 National Health Objectives

Priority Areas

HEALTH PROMOTION

1. Nutrition
2. Physical Activity and Fitness
3. Tobacco
4. Alcohol and Other Drugs
5. Sexual Behavior
6. Violent and Abusive Behavior
7. Vitality and Independence of Older People
8. Environmental Health
9. Occupational Safety and Health Services
10. Unintentional Injuries
11. Maternal and Infant Health
12. Immunization and Infectious Diseases
13. HIV Infection
14. Sexually Transmitted Diseases
15. High Blood Cholesterol and High Blood Pressure
16. Cancer
17. Other Chronic Disorders
18. Oral Health
19. Mental and Behavioral Disorders
20. Health Education and Preventive
21. Surveillance and Data Systems

Objectives

SPECIFICALLY TARGETING PRIMARY AND SECONDARY SCHOOLS

Healthy People 2000 is a broad-based initiative led by the U.S. Public Health Service (PHS) to improve the health of all Americans through an emphasis on the prevention, not just the treatment, of health problems over the next decade. Forming the cornerstone of this effort are national health objectives to reduce preventable death, disease, and disability.

The year 2000 health objectives succeed the 1990 health objectives set in 1980. While significant improvements have been made in the nation's health profile over the past decade, gains have not been universal. Many of the new objectives will aim specifically at improving the health status of certain groups of people who bear a disproportionate share of disease, disability, and premature death compared to the general population. This emphasis will be especially critical in the 1990s since many of these groups will also be experiencing a faster rate of growth than the population as a whole.

The publication of the health objectives, *Healthy People 2000*, will set out a prevention agenda for the 1990s with quantifiable targets for improv-

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1. Healthy People: The Surgeon General's report on health promotion and disease prevention, background papers. Washington, DC, US Dept. of Health, Education and Welfare, US Government Printing Office, 1979.
2. Promoting Health/Preventing Disease: Objectives for the nation. Washington, DC, US Dept. of Health and Human Services, US Government Printing Office, 1980.

ing health status, reducing risk factors for disease and disability, and improving services. Emerging from the final drafting phase are priorities in the areas of health promotion, health protection, and preventive services. The specific health problems of different age groups will be highlighted in separate sections of Healthy People 2000, as will the need for surveillance and data system improvements.

1.19 Increase to 95 percent the proportion of school lunch and breakfast services with menus that are consistent with the Dietary Guideline for Americans. (Baseline data available in 1989)

2.11 Increase to at least 45 percent the proportion of children and adolescents in grades 1 through 12 who participate in daily school physical education programs. (Baseline: 36 percent in 1984-1986)

2.11a Increase to at least 40 percent the proportion of children in grades 1 through 6 who participate in daily school physical education programs. (Baseline: 32 percent in 1984-1986)

2.11b Increase to at least 50 percent the proportion of children and adolescents in grades 7 through 9 who participate in daily school physical education programs. (Baseline: 44 percent in 1984)

2.11c Increase to at least 45 percent the proportion of adolescents in grades 10 through 12 who participate in daily school physical education programs. (Baseline: 45 percent in 1984)

2.12 Increase to at least 70 percent the proportion of teachers who teach physical education who spend 30 percent or more of class time on skills and activities that promote lifetime physical activity participation. (Baseline data unavailable)

3.9 Include tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of comprehensive school health education. (Baseline: Anti-smoking education was provided by 78 percent of school districts at the high school level, 81 percent at the middle school level, and 75 percent at the elementary school level in 1988)

4.16 Expand to all school districts and private schools the provision of appropriate primary and secondary school educational programs on alcohol and other drugs, preferably as part of comprehensive school health education. (Baseline: 63 percent provided some instruction, 39 percent provided counselling, and 23 percent referred students for clinical assessments in 1987)

5.16 Expand to all school districts the development of policies on the provision of school-based family life and sex education. (Baseline: 87 percent of the 200 largest school districts had policies supporting sex education in 1989)

6.15 Extend to at least 45 states training of public and private school teachers in the identification, referral, and prevention of physical and sexual child abuse, consisting of a minimum of 2 hours per year. (Baseline data unavailable)

10.14 Increase academic instruction on injury control to at least 6 hours per year per student in 50 percent of public school systems (grades K through 12). (Baseline data unavailable)

10.16 Increase continuing education on injury prevention, consisting of at least 3 hours per year, to at least 50 percent of primary and secondary school teachers (including coaches). (Baseline data unavailable)

10.18 Extend requirement of the use of appropriate head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events. (Baseline: Only National Collegiate Athletic Association football, hockey, and lacrosse; high school football; amateur boxing; and amateur ice hockey in 1988)

12.21 Increase to at least 95 percent the proportion of children ages 5 through 18 who have up-to-date official immunization records that use uniform formats and common guidelines for determining current immunization status. (Baseline: Official records varied in form and content in 1989)

13.12 Increase to at least 95 percent the proportion of secondary schools that have HIV education curricula for students in grades 7 through 12. (Baseline data unavailable)

19.8 Increase to at least 95 percent the proportion of nine-year-olds reading at a basic level or higher, thereby weakening the link between poor school performance and future health problems. (Baseline: 83.3 in 1983-1984)

19.8a Increase to at least 80 percent the proportion of black nine-year-olds reading at a basic level or higher, thereby weakening the link between poor school performance and future health problems. (Baseline: 43.9 in 1983-1984)

19.8b Increase to at least 85 percent the proportion of Hispanic nine-year-olds reading at a basic level or higher, thereby weakening the link between poor school performance and future health problems. (Baseline: 48.5 in 1983-1984)

19.9 Reduce the proportion of high school dropouts to no more than 8 percent among youth ages 16 through 24, thereby reducing risks for multiple problem behaviors and poor health. (Baseline: 12.6 percent in 1985)

Montana youth continue to die at unacceptable rates from preventable causes of death–unintentional injuries, suicides, and homicides. Too many of our youth suffer from disabling conditions caused by motor vehicle accidents, falls, drowning, poisoning, teenage pregnancy, child abuse, drug and alcohol abuse, mental problems, and smoking. Most of these tragic losses of life and health are preventable.

19.9a Reduce the proportion of high school dropouts to no more than 10 percent among Hispanic youth ages 16 through 24, thereby reducing risks for multiple problem behaviors and poor health. (Baseline: 27.6 in 1985)

19.9b Reduce the proportion of high school dropouts to no more than 8 percent among black youth ages 16 through 24, thereby reducing risks for multiple problem behaviors and poor health. (Baseline: 15.1 in 1985)

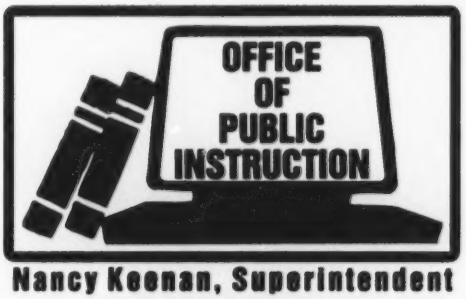
20.14 Increase to at least 50 percent the proportion of the nation's elementary and secondary schools that provide a planned and sequential kindergarten through grade 12 program of comprehensive school health education. (Baseline: About 5 percent in 1988)

Duplicate objective (an objective that appears in more than one priority area).

Note 1: A lower-case letter after an objective number indicates that the objective is a Special Population Target under an objective for a broader population group, often the total population.

Total number of records in report = 22

Note 2: The objectives on this list specifically target primary and secondary schools. However, there are other draft objectives not found on this list that are relevant to schools as well, in particular those targeting work sites or a broad array of settings. Please refer to the complete set of draft objectives for a more comprehensive set of objectives relevant to schools.



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